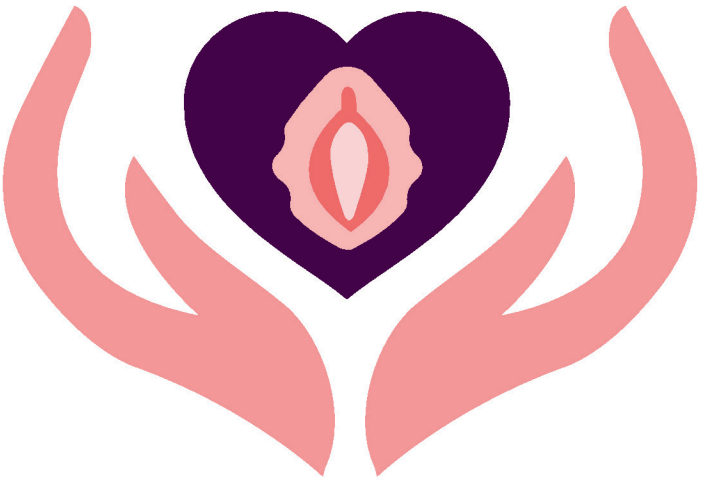


COMMUNICATION GUIDE

for activists working to end

FEMALE GENITAL CUTTING

sahiyo

United Against **Female Genital Cutting**

INTRODUCTION

Much of the passion that drives activism and advocacy springs from people's instinctive rejection of female genital cutting (FGC), and their commitment to working against it. BUT, does a commitment to end FGC mean that we know how to ***talk*** *about FGC?*

Sometimes despite our good intentions, discussion can end up doing more harm than good. While there are certainly some audiences that respond exactly as hoped, communications that are targeted at "the general public" and not catered to specific communities can often fall on deaf ears, or worse, perpetuate the continuation of the harmful practice.

This guide seeks to provide activists with tools and tips on how to engage in effective advocacy campaigns on FGC.

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WHY COMMUNICATION MATTERS:

UNDERSTANDING 'FRAMES'

(Adapted from the Narrative Initiative Toward New Gravity)



Effective activism relies on telling the right story in the right way at the right time.

What are 'Frames' and Why do They Matter?

The world around us is a diverse, complex place. Our brains have to constantly process a flood of information that we receive through language, images and symbols. A lot of times, new information is different or in conflict with what is familiar to us.

So how do human brains make sense of all this? How do we organize the world to make it easier for our brains to process?

We do this through patterns. Subconsciously, our brains interpret the messages and information we constantly receive by organising it all into patterns and categories based on common themes or stereotypes. Cognitive scientists refer to these patterns as 'Frames' — mental structures that shape the way we see the world.

We use framing to articulate our world views and beliefs, and inevitably, *framing becomes closely associated with language.* We use words in a language to define and communicate our 'frames' and beliefs, and over time, those words evoke certain unconscious, intuitive and emotional responses in us.

Understanding framing and its link to language is important for us as activists if we wish to change other people's frames or mindsets.

"Even small changes in framing will alter how we think on an issue"

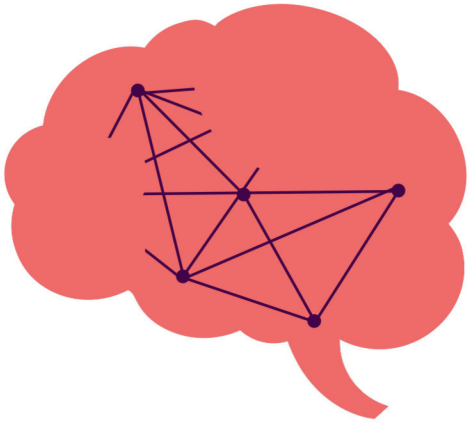
~ Susan Nall Bales

For example, think of the words "people with disabilities" versus "handi-capped" or "differently abled"? Or think of the words "retarded" versus "special needs"? If you were a parent of a child with blindness, autism, or cerebral palsy, which terms would you prefer society to use? Similarly, think about environmental "regulations" versus environmental "protections". If a government wants businesses and citizens to follow guidelines and laws about environmental care, which term would evoke more positive responses?

What else do we need to know about frames?

FOREGROUNDING AND BACKGROUNDING

The human mind can hold various value-systems at the same time (for instance, a person may be generous in one context, and thrifty in another). The mind can also hold multiple, even opposite, frames at the same time as well (for instance, within the South Asian Bohra community, some Bohra community members may not agree with female genital cutting but still follow the instructions of the head religious leader, the Syedna, because they believe he is infallible). Therefore, framing is not a matter of message manipulation, but instead is a means of foregrounding certain frames, while backgrounding others.



META-NARRATIVES Many of the frames that we hold in our minds can be classified as *'meta-narratives'.* These are overarching, foundational narratives or stories that structure the beliefs, identity and culture of entire societies or communities. In Muslim societies, for instance, the concept of one God passing down guidance and teachings through Prophets (the last one being Prophet Mohammed), is a meta-narrative.

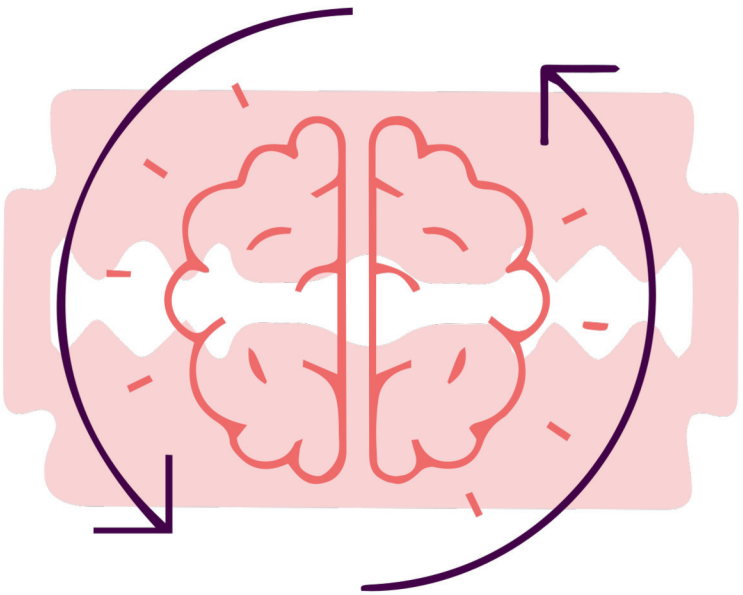
The main characteristics of meta-narratives are that they are - **deeply embedded** in a society - **repeated and reproduced** consistently by members of that society, hence reinforcing our belief in them
- **powerful** because they are **invisible** - they shape our minds and actions unconsciously.

We use our meta-narratives to interpret almost everything in the world, and often, friction can occur when individuals or groups with different meta-narratives encounter each other.

For example, patriarchal societies are structured on the meta-narrative that males, being stronger than females, hold power and dominance in society. This influences every aspect of patriarchal culture, even if its followers are not consciously aware of it. For instance, some cultures expect a bride to live with her husband's family and change her surname, and many don't question these social norms, because our patriarchal meta-narrative has trained us to think that this is the way the world is. Feminists clash with these beliefs and practices because they hold a different meta-narrative that questions the very basis of patriarchy.

CAN META-NARRATIVES BE CHANGED?

The practice of female genital cutting, as you might have guessed by now, is also a product of a meta-narrative or a frame that our society holds. Over years of consistent repetition from generation to generation, it has become a social norm: a deeply entrenched ritual that a society may follow without questioning it because that's just the way it is.



However, meta-narratives can be changed through consistent community dialogue and activism, and societies can be convinced to end female genital cutting.

Social change is slow, hard work - much like pushing a heavy rock up a steep hill. Sometimes, the rock will roll back down despite our valiant efforts. We know the terrain will be tilted against us because we are struggling against deeply rooted frames about gender and religion.

Changing narratives - the shifting of consciousness and values - is a long game. It is not just about finding the right words to spread particular views, but also the ability to activate the underlying values and beliefs behind those views. It is about normalizing justice.

Our work, in the long run, is not to push rocks up a hill. It is to reshape the terrain itself so that we have gravity on our side.

"Ideas at first considered outrageous or ridiculous or extreme, gradually become what people think they've always believed... Change is rarely straightforward."

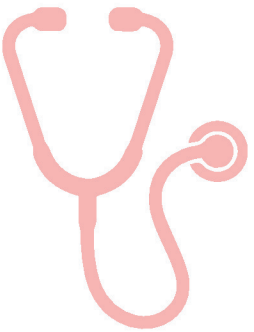
~ Rebecca Solnit

ENDING FEMALE GENITAL CUTTING:

CHALLENGES WITH CURRENT COMMUNICATION APPROACHES

(Adapted from Portland State University College of Urban and Public Affairs' You Can Get There from Here, April 2008)

Health Approach



Often, as activists, we focus on pointing out the negative consequences of FGC - particularly the negative health consequences. We believe this is sufficient to motivate people to act against FGC.

But is it really sufficient?

During the 1960s and ’70s, women’s groups in many African nations held awareness campaigns about the harmful effects of FGC. Moreover, doctors in Nigeria, Sudan and Somalia began reporting in medical journals about the harmful consequences of FGC, thus beginning intervention strategies to end FGC using a health approach.

This approach discusses medical complications (such as severe pain and bleeding, chronic infections, infertility, pregnancy problems, and pain during sexual intercourse) as a persuasion tactic against FGC. The approach is based on the belief that all communities recognize the wish for good health. Many consider it an important approach for communities that believe FGC has medical benefits.

But campaigns using the health approach come with their own challenges:

a) What do we really know for sure? Medical "facts" about the health consequences of FGC are hard to obtain. In some cases, there are discrepancies between these "facts" about negative consequences and what women experience in real life due to FGC. The potential risks of FGC, which a lot of research assumes to be true, are based on conclusions from purely anecdotal data or only pulled from certain regions of the world. Most researchers have been unable to find large populations of 'cut' women willing to participate in studies. Thus most data continues to be drawn from case studies and small samples. Even within these small-scale research projects, little to no research has been collected on the long-term health consequences of Type I or the 'sunnah' variety of FGC believed to be widely practiced in Asia.

b) FGC versus 'circumcision' An additional challenge is that some communities and religious leaders condemn the more severe types of FGC (Types II and III) by recognizing their negative health consequences, but they simultaneously defend the 'sunnah' version (Type I and/or Type IV) by claiming it is just mild circumcision and not harmful. The following quote indicates just such a division:

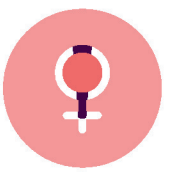
"The FGC here is not the same with the one in Africa ... I wonder why people make it into an issue ... If this is about pain and human rights, the males can protest because they too are cut. For us, the resistance against FGC is unreasonable especially considering how FGC has helped those women with a very high libido who feel difficult to concentrate in their activities because they get aroused easily."

~ Member, Majelis Ulama of Indonesia
Islamic Relief Canada Study, 2013-2016, p.16

Experience and research demonstrate that a health-only approach is ineffective in dismantling the growing notion that some forms of FGC are acceptable.

c) The ‘medicalization’ challenge

There is a growing trend of ‘medicalization’ among some FGC-practicing communities, in which they now get health-care providers (doctors, nurses) to perform FGC in a sterile environment. This gives the impression that FGC is medically safe, and many activists and doctors are speaking out about the dangers of such a misguided impression. There has been debate even amongst some health professionals who argue that ‘minor’ forms of FGC should be recognized as culturally acceptable. [1]



In 2016, The Economist – a prestigious British news magazine – entered this debate by publishing a controversial editorial condoning ‘mild’ FGC. The editorial argued that since global campaigns to completely ban FGC have been unsuccessful for decades, governments should try a ‘new approach’ in which the ‘worst forms’ of genital cutting are banned in favor of ‘a symbolic nick from a trained health worker’. The Economist’s editorial was met with both praise from FGC practitioners who felt validated, and firm condemnation from survivors, activists, and international organizations who recognize even ‘mild’ FGC as a form of gender-based violence.

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1 The practice of nicking was briefly endorsed by the American Academy of Pediatrics (AAP) as a way of meeting families’ perceived cultural requirements while avoiding more severe physical injury. However, after advocates’ efforts to educate the medical community on the discrimination inherent in all forms of FGC, the AAP retracted its policy and issued a statement consistent with WHO and the U.N. to not endorse any form of FGC.

Rights-Based Approach

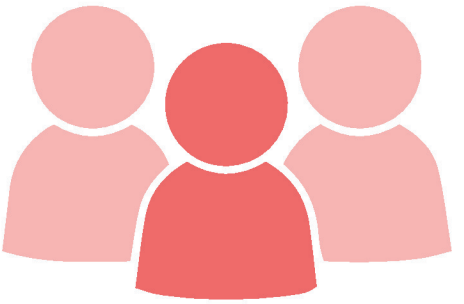


As activists, we agree that FGC is a form of violence, a violation of child rights, women's rights and human rights. Some activists make this the sole focus of their arguments against FGC, emphasizing the issue of consent: FGC is a violation of rights because it is done to a girl child without her informed consent.

However, while the lack of consent in FGC is a legitimate concern, supporters of FGC often defend it by comparing it to male circumcision. Most boys in the U.S. and/or boys coming from Abrahamic religious backgrounds are circumcised in infancy, without their consent. This, too, can be viewed as a legitimate concern - the issue of consent does apply to both male and female genital cutting.

In such a situation, individual activists could consider for themselves how they view male circumcision. For those who would like to keep the focus on FGC, consider the fact that in addition to consent, intent is also an important factor: while FGC is most often linked with influencing female sexual desire or pleasure, male circumcision is almost never done with the intention of affecting the male sexual experience.

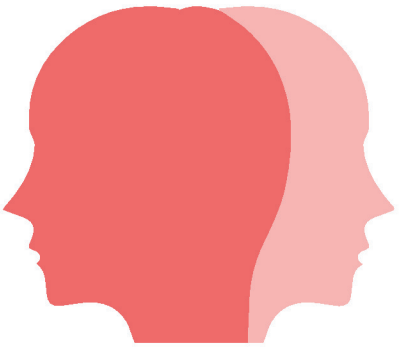
‘Individual Responsibility’ Approach



Some activists emphasize the idea that ending FGC is a matter of individual responsibility. They believe that a girl going through FGC is the fault of one person (the parent, for example), and if that person says no to FGC, then the practice cannot occur. When this approach is taken, the activist often ends up asking questions - or making assumptions - about what people could or should have done to ensure that the girl didn’t get cut (like calling the police, for example).

The limitation of this approach is that activists tend to take a cognitive ‘blindness’ to systemic factors that might lead to a girl getting cut. In other words, activists ignore the more universal reasons why people might continue FGC and tend to focus on blaming individuals. These other systemic reasons include FGC being promoted as a religious or cultural necessity, people raised with the belief that authority cannot be questioned, or fear of being disowned by the community. But even for a sympathetic activist, sometimes these systemic factors are harder to see and difficult to cognitively grapple with.

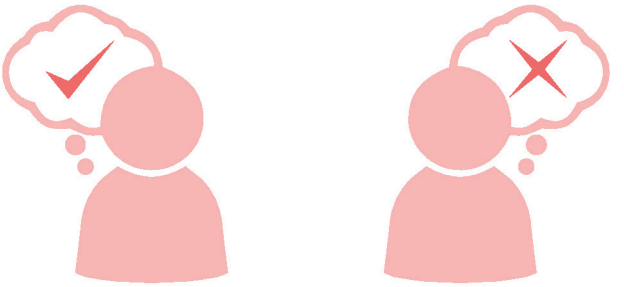
‘Us versus Them’ Thinking



Yet another important reason why conversations about FGC may not have the desired effect in preventing someone from continuing the practice is that activists may unintentionally reinforce the divide between ‘us’ and ‘them’.

For instance, some activists promote the assumption that all practitioners of FGC must be blind followers or ignorant. We are all naturally inclined to identify most closely with people more like us, and rather than helping to bridge the differences between different groups (those who want to end FGC and those who promote it), activists might reinforce the sense of division between the groups.

Reasonable Mode versus Rhetorical Mode



Another factor that makes it difficult to talk productively about FGC relates to what can be called ‘Reasonable Mode’ and ‘Rhetorical Mode’ in people’s thinking and communication.

When a person is in Reasonable Mode, they are open to new information, practical understanding and problem-solving.

In Rhetorical Mode, the person is focused on opposition, defending their position against yours, identity-based thinking, and resistance to new ideas.

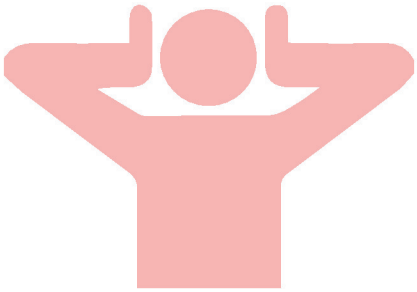
In Rhetorical Mode there are winners and losers; in Reasonable Mode, everyone in the conversation is working towards the same goal.

The topic of FGC can contrast one group against another. It is possible to have a Reasonable Mode discussion on why one group believes in FGC and another doesn’t, and what to do about it, but it is also very easy for such discussions to provoke the Rhetorical Mode, as people instinctively take ‘sides’. People may get defensive rather than opening up.

Specific **language choices** make a difference here, too. Think of the association between ‘frames’ and language mentioned earlier in this guide. Those who practice and support FGC prefer using colloquial terms like ‘khatna’, ‘sunnah’, or ‘female circumcision’. They perceive it as a completely different frame from ‘Female Genital Mutilation’. On the other hand, many activists working to end FGC choose to use the term female genital mutilation, believing that this term correctly identifies the harm being done to a girl child’s genitalia.

It is important to remember that terms like ‘female circumcision’ or ‘cutting’ are a relatively objective way of referring to the practice. ‘FGM’, on the other hand, shows strong opposition to FGC and may cause someone to immediately shut down a discussion or become defensive in conversations.

Guilt and Denial



FGC is a topic that many community members from an FGC-impacted community may find especially difficult or uncomfortable to talk about - even to think about. Sometimes, activists underestimate people’s ability to deny a truth that seems to implicate them or their way of life in a serious way. Guilt and denial are natural triggers for Rhetorical Mode, as people look for ways of arguing away their discomfort:

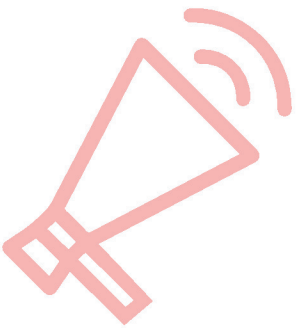
- “This is freedom of religion.”

- “Well, that certainly hasn’t been my experience.”

- “We don’t do what the ‘Africans’ do.”

- “If anything, I/we are the victims because our peaceful reputation as Bohras has been tainted.”

So, how can we talk about FGC, then?



We have discussed, above, some of the communications ‘traps’ that activists can encounter as they try to work towards ending FGC.

This does not imply that activists should stop talking about FGC (and certainly not that they should stop working to prevent FGC!). Only that as activists, we do need to be careful about how we discuss FGC with a wider community, and we need to think about what we are hoping to achieve in our communications.

Here are some tips that might help activists sidestep the unfortunate conversation challenges associated with FGC:

- ✔ **Highlight practical steps that can be taken ('solutions', rather than just 'the problem').**
- ✔ **Use a multi-pronged approach discussing FGC from multiple perspectives - health, consent, intention, human and child rights, etc.**
- ✔ **Take advantage of people's interest in good news about programs/ ideas that work. For instance, Sahiyo's study shows that 81% of survey respondents do not want FGC to continue. Point out that this is significant even if the survey had a relatively small number of respondents (385 respondents).**
- ✔ **Find ways of linking the issue to 'all of us'. For instance, we should all be invested in community wellness, we want to make sure that no one in our community is ever harmed by FGC.**
- ✔ **While talking about the reasons why FGC continues, be careful not to blame the parent or individual choices and behaviour - focus instead on systemic pressure, religion, fear of social exclusion, etc.**
- ✔ **Use language that helps your audiences identify with the topic (i.e. use 'khatna' instead of 'FGM'), rather than using language that creates distance between them and you.**

Of course, these tips are easier said than done, but to move a step closer to ending FGC, we need to be able to move public discussions forward in constructive ways.

HOW TO HAVE EFFECTIVE CONVERSATIONS ON FGC

(Adapted from Exhale's ProVoice Approach)

Effective communication is a skill worth cultivating, particularly for activists. **In order to bring about a change in people's mindsets and worldviews, we must find ways to respectfully and sensitively engage in discussions with our family, friends and the wider community.** This section explores the various facets of conversation: from the power of listening and the method of storytelling, to the challenges of acknowledging nuance and understanding the importance of continued dialogue.

1) Listening

The simple act of genuinely listening to another person is powerful. Listen with your full attention, without judgment or assumptions. Simply listen. Instead of giving advice or telling a person what to feel or do, be a sounding board and brainstorm options. However, setting appropriate limits is important for effective communication. If someone is being hateful towards you, it is okay to not continue the conversation.

a) Use open-ended questions: Unlike leading questions or close-ended questions that can be answered only by yes or no, open-ended questions help people explore their own truths and connect with their own inner strength. Ask "What are you feeling?" instead of "Do you feel all right?"

b) Use reflective language:

Use phrases such as "I hear

- you're feeling…" or
- "It sounds to me like…"

coupled with more tentative statements like

- “I wonder if you’re feeling…?” or
- “Did I get that right?”

This helps people to name what they are experiencing, invites them to correct your understanding, and conveys your sincere interest in what they have to say. When you reflect back the language that people use to describe their own experience, you meet them on their own ground.

Some FGC-related words to keep in mind as you listen to someone’s specific language include how they refer to FGC – “khatna,” “FGM”, “FGC”, “female circumcision”, “procedure”. Using the same words as the speaker lets her know that you respect her point of view, even if it’s not your own.

c) Validate personal experiences: Stigma and trauma can often make people feel like they are alone, or that they are the only ones feeling that way. **When you initially listen to their stories, it is not the time to engage in a political fight or an academic argument.** Whether it is a woman sharing her experience of FGC or someone who states that FGC must be done for religious reasons, help the person feel heard, without judgment. You can share your views at a later stage.

2) Sharing Stories During Conversations

There is an art and a craft to storytelling that can be intimidating for people who find it hard to believe they have any story worth sharing, especially if it's about something personal, taboo, or hidden. Utilizing storytelling methods in conversation is helpful because it can support an individual's ability to think through what it is she wants to say, whom she wants to say it to, and what she hopes will happen as a result, while retaining significant control over the use and distribution of her narrative.

a) Know the risks: Sharing personal stories could help a person feel more empowered and connected to other friends or family members who have undergone FGC. It can also come with personal risks: a person may feel more vulnerable and alone after sharing her story, or might be shamed by others.

Don't pressure, coerce or shame others into telling their story, even if it is to promote a cause they believe in. Work to create the conditions necessary for someone to feel encouraged and supported to share their story with you.

b) Use whole stories, not talking points: Stories have the ability to persuade, influence, inspire, and galvanize people to action. Human, vulnerable, authentic personal stories don't fit easily into talking points, but they have incredible power to connect with others across differences. Work to create the conditions necessary for someone to feel encouraged and supported to share their story with you.

3) Embrace Grey Areas

A person who has undergone FGC may have experienced pain and sadness and/or nothing at all. They may want to keep it private and need emotional connections with others. They may think FGC is wrong and still believe it is a religious right. They may feel many other combinations of emotions that could seem inconsistent at the outset. It is important to recognize that multiple truths can live together simultaneously.

Issues around how FGC has happened and her feelings around it are not always black and white, and to open the door to change and new insights, we need to acknowledge and explore the grey areas. It is helpful to use a **'both/and' approach instead of an 'either/or' approach.**

a) Change your perspective: Sure, it may be easier if the whole world saw the issue in the same way you do, but that's not realistic. Conflict exists because we are human, and because our different backgrounds, values, and beliefs mean that we perceive the world and its issues in unique, diverse ways.

Hold space for universal human truths – such as our shared ability to be compassionate and loving – and recognize some experiences as specific and particular, such as the experience of some women going through physical and psychological pain due to FGC while others state they did not experience such consequences. The key is to show support and respect for all.

4) Continued Conversations

Social change takes time, and often we may not get the results that we want in one conversation. Therefore, it is important to take stock of what has occurred during the course of the conversation, and allow all parties involved some time and space to reflect on it. However, do not let it be your last conversation. Change can only happen if we are constantly in dialogue with each other.

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KEY TO EFFECTIVE CONVERSATIONS ON FEMALE GENITAL CUTTING



LISTEN

Don’t judge. Give your full attention. Ask open-ended questions.



SHARE

Storytelling supports, empowers and connects, but also recognize the risks.



REFLECT

Acknowledge nuance. Respect all views.



CONTINUE

Make this your first, not last, conversation. Re-engage.

PRACTICAL ETHICS

ETHICS IN THE NEWS

Does Female Genital Mutilation Have Health Benefits?

The Problem with Medicalizing Morality

Published August 15, 2017

By Brian D. Earp (@briandavidearp)

** Please note: this piece was originally published in Quillette Magazine.*

While this article predates the Michigan court decision, it serves as an excellent case study in how framing shapes discussions of female genital cutting. The article demonstrates the complexity of navigating various communication frames connected to FGM/C – illustrating how different understandings of the same issue can lead to vastly different perceptions and policy approaches.

Four members of the Dawoodi Bohra sect of Islam living in Detroit, Michigan have recently

been indicted on charges of female genital mutilation (FGM). This is the first time the US government has prosecuted an “FGM” case since a federal law was passed in 1996. The world is watching to see how the case turns out.

A lot is at stake here. Multiculturalism, religious freedom, the limits of tolerance; the scope of children’s — and minority group — rights; the credibility of scientific research; even the very concept of “harm.”

* * *

To see how these pieces fit together, I need to describe the alleged crime.

The term “FGM” is likely to bring to mind the most severe forms of female genital cutting, such as clitoridectomy or infibulation (partial sewing up of the vaginal opening). But the World Health Organization (WHO) actually recognizes four main categories of FGM, covering dozens of different procedures.

One of the more “minor” forms is called a “ritual nick.” This practice, which I have argued elsewhere should not be performed on children, involves pricking the foreskin or “hood” of the clitoris to release a drop of blood.

Healthy tissue is not typically removed by this procedure, which is often done by trained clinicians in the communities where it is common. Long-term adverse health consequences are believed to be rare.

Here is why this matters. Initial, albeit conflicting reports suggest that the Dawoodi Bohra engage in this, or a similar, more limited form of female genital cutting – not the more extreme forms that are often highlighted in the Western media. This fact alone will make things rather complicated for the prosecution.

The defense team has already signaled that it will emphasize the “low-risk” aspect of the alleged cutting, claiming that it shouldn’t really count as mutilation. It is, after all, far less invasive than Jewish ritual male circumcision, which is legally allowed on minors in the US, no questions asked.

Based on this discrepancy, if attorneys for the Bohra can show a gendered or religious double standard in existing law, the ramifications will be not be small. Either male circumcision will have to be restricted in some way, or “minor” forms of FGM permitted. The outcome either way will be explosive.

I will dig into the male-female comparison—and explore its legal implications—later on. But the law will not actually be my main focus. Instead, what I’ll suggest in this piece is that the question of health consequences, whether positive or negative, should not exhaust the ethical analysis of these procedures.

There is more to “good” and “bad” than healthy versus unhealthy.

In fact, as the Bohra case will show, there are serious, even dangerous downsides to medicalizing moral reasoning – and to moralizing medical research. On both counts, I argue, at least when it comes to childhood genital cutting, apparently biased policies from the WHO are making things a great deal worse.

* * *

“The tendency today is to roll over and ‘scientify’ everything,” says Julian Savulescu, a philosopher at the University of Oxford. He goes on: “Evidence will tell us what to do, people believe.” But people are getting it wrong. When you reduce your ethical analysis to benefit-risk ratios, you miss important questions of value.

Take the ritual nick, or male circumcision for that matter, and ask yourself what might be morally problematic about these customs, benefits and risks to one side. A few possibilities come to mind.

First, the perceived need to cut children’s genitals—whatever their sex or gender, and however severe the cutting—as a precondition for accepting them into a community should plausibly be questioned, rather than taken for granted.

Part of the reason for this is that, regardless of health consequences, many individuals whose genitals were cut when they were children grow up to feel disturbed by what they take to be an intimate violation carried out when they were too young to understand or refuse.

That prospect alone should weigh heavily in parents' minds when contemplating these sorts of practices. The genitals are not like other parts of the body. People assign different meanings to having their "private parts" cut or altered, and they do not always appreciate, much less value or endorse, the intentions of the ones who did the cutting.

For example, realizing that they needed to be "marked" or "purified"—that they were not seen as perfect the way they were born—can be hard to swallow for many "cut" individuals, even if no tissue is removed. A person can always undergo a genital procedure later on in life, if that is what they want. But those who resent being cut cannot "undo" what has happened.

There is also the possibility of psychological harm, over and above the issue of contested "meanings." Although it is hard to measure scientifically, such harm undoubtedly varies with the mental and emotional disposition of the child and the timing and circumstances of the cutting.

Some Bohra women, for example, report feeling emotionally traumatized by what happened to them when they were little girls—the confusion, the pain, the embarrassment of being held down with their genitals exposed—while others insist that they didn't mind, and are proud of being cut. (Similar ambivalence can be found among religiously circumcised men.)

Both kinds of testimony should be taken seriously. Yet those who claim there is no harm in "mild" forms of childhood genital cutting often ignore such individual differences. Instead, they point to vague, impersonal averages or talk in abstract, theoretical terms.

Not uncommonly, they claim to be speaking on behalf of their entire religious community, as though it were a monolith (at least with respect to attitudes about cutting).
Meanwhile, dissenters from within the community are often ridiculed, waived away, or simply silenced: those who speak out may be faced with "excommunication and social boycott."

The power of tradition to smother resistance can be intense.

* * *

All of that said, even if “health consequences” were the only thing that mattered morally, the fact that a given act of cutting is less severe than some alternative does not eliminate the need for concern. This is because any time a sharp object is brought into contact with sensitive flesh, it poses some risk of physical harm, however small.

The knife could slip. Nerve damage could occur. Bleeding or infections could ensue. And while those factors might not be ethically decisive for more “neutral” parts of the body—even ear-piercing and cosmetic orthodontics carry risks—a person might reasonably conclude that any chance of adverse outcomes is too great when it comes to their sexual organs.

Finally, if health consequences in the form of “health benefits” are seen as legitimizing childhood genital cutting—as is often suggested in the case of male circumcision—then proponents of female genital cutting (FGC) who are loath to give up their valued custom might be motivated to find such benefits in order to appease their critics.

They might even succeed in doing so. For reasons I will get into later, it is not actually implausible that certain “mild” forms of FGC, such as neonatal labiaplasty, could reduce the risk of various diseases.

But that wouldn’t make the cutting a good idea. Instead, I will argue that children should be free to grow up with their genitals intact—no nicks, cuts, or removal of tissue—even if the risk of adverse health consequences turns out to be mild, and even if certain health benefits can be found.

* * *

What about the legal issues? I can’t say too much about the particulars of the forthcoming trial because I don’t want to prejudice the outcome, but I can make some general observations.

To be frank, the US government has probably picked the worst possible case to show it is “serious” about addressing FGM. It is setting itself up for plausible accusations of anti-Muslim bias, as well as sexist double standards (as I hinted at before).

The main reason for this is as follows. If convicted, the Muslim minority defendants face 10 years to life in prison for allegedly practicing a form of FGM that is less physically invasive than other forms of medically unnecessary genital cutting that are legally tolerated in Western countries.

I have already mentioned male circumcision. There is also intersex genital “normalization” surgery (which has been brilliantly discussed in this context by Nancy Ehrenreich); supposedly virginity-signaling hymen “repair” surgeries (which I have written about elsewhere); and at least some so-called “cosmetic” female genital operations, which are increasingly being carried out on minors.

I promised I would tackle the male-female comparison, so let’s look at male circumcision (some details are needed to spotlight the inconsistencies, but I hope you will bear with me). Unlike the “ritual nick,” which does not typically alter the form or function the external (female) genitalia, male circumcision permanently alters both.

To begin with, it—by definition—removes most or all of the foreskin, which is about 50 square centimeters of elastic tissue in the adult organ and the most sensitive part of the penis to light touch.

It creates a ring of scar tissue around the shaft that is often discolored.

It makes sexual activities that involve manipulation of the foreskin—see here for a NSFW video—impossible. And it exposes the head of the penis, naturally an internal organ, to rubbing against clothing, which can cause chafing and irritation.

Those are the guaranteed effects. Possible “side effects” include painful erections if too much skin is removed (the penis is very small at birth and the choice of where to cut is essentially a guess), partial amputation of the glans due to surgical error, infections, cysts, fistulas, adhesions, pathological narrowing of the urinary opening, severe blood loss, and rarely—except in tribal settings where it is common—death.

Yet it is perfectly legal in the United States to perform a circumcision on a male child for any reason. Religion, culture, parental preference—regardless of the motivation, the cutting is tolerated, and you don’t need a medical license to do it.

In fact, even ultra-Orthodox Jews who perform an unhygienic “oral suction” form of circumcision, in which the circumciser takes the boy’s penis into his mouth and sucks the wound to staunch the bleeding, are legally permitted to do so without state certification or oversight. This is despite confirmation of more than a dozen cases of herpes transmission, two cases of permanent brain damage, and two infant deaths likely caused by the practice between 2004 and 2012.

Those are just the figures for New York City. But still there are no legal restrictions. As the bioethicist Dena Davis has pointed out, “states currently regulate the hygienic practices of those who cut our hair and our fingernails, so why not a baby’s genitals?”

She means “baby boy’s” genitals; baby girls’ genitals are protected by law.

The Bohra defense team will likely flag these inconsistencies. If ritual male circumcision is not only legally permitted but completely unregulated in the US, they will argue, then how can a procedure that carries fewer risks and is less physically damaging be classified as a federal crime? They will also point to the religious significance of “female circumcision” among the Bohra. They will ask: aren’t religious practices granted strong legal protections in the United States and other Western countries?

The prosecution will almost certainly make two moves in response. First, they will argue that FGM is not truly a religious practice, but is “merely” a cultural tradition, because there is no mention of female circumcision in the Koran. And second, they will point out that male circumcision has been linked to certain health benefits, whereas FGM “has no health benefits” (as stated by the WHO).

* * *

But things are not so simple. It is true that female circumcision is not mentioned in the Koran; but neither is male circumcision. And yet the latter is widely regarded as a “religious” practice not only within Judaism but also Islam. As Alex Myers notes, “if we defer to religious justifications, we shall find that in many cases, the circumcision of female as well as male children could be permitted on this basis.”

How could that be so? In her landmark paper entitled, “Male and Female Genital Alteration: A Collision Course with the Law,” Dena Davis notes that “binding religious obligations” can stem from oral traditions and other “extrabiblical sources,” such as rabbinic commentaries or papal encyclicals in the case of Judaism or Christianity. Likewise, “Islam looks to other sources to interpret and supplement Koranic teachings.”

One such source is the Hadith—the sayings of the Prophet Mohammed—which is the other major basis for Islamic law apart from the Koran.

Both male and female circumcision are mentioned in the Hadith. Based on their reading of the relevant passages, some Muslim authorities state that “circumcision” of both sexes is recommended or even obligatory, while others draw a different conclusion. There is no ultimate authority in Islam to settle such disputes, however, so debate continues to this day.

What this means is that, until a consensus is reached in the Muslim world, the status of female genital cutting as a “religious” or “cultural” practice will depend on each community’s local evaluation of secondary Islamic scriptures. Dawoodi Bohra clerics view the practice as religious.

This leads to an uncomfortable thought. In the West, we seem more or less unfazed by the religiously sanctioned cutting of boys’ genitals; but we go into a panic over less severe procedures performed on the genitals of girls by equally pious parents.

In fact, we bend over backwards to convince ourselves that the latter procedures are “not actually religious” by selectively citing scholars who agree with us—as though not being “religious” somehow made a practice less worthy of being respected, or being “religious” made it morally OK. Neither of those propositions follow.

Finally, we attribute evil motives to the parents who circumcise their daughters, when the same parents almost invariably also circumcise their sons, sometimes more invasively, and often for identical reasons. (The stereotype that female circumcision is “all about” misogyny and sexual control, while male circumcision is about neither, is one that I, and many other scholars, have deconstructed elsewhere: see here for a fairly short summary. Suffice it to say the claim is not true.)

So who are we kidding? The overwhelming majority of American parents who circumcise their sons do it for “cultural” rather than religious reasons, and few seem concerned to bat an eye. Even many Jews who circumcise are committed atheists (and for all I know, so are many Muslims). Although the law may treat “religion” as a special, separate category, the religious versus “cultural” status of male or female genital cutting is not what drives our different moral judgments.

* * *

So maybe it’s “health benefits.” Maybe we think male circumcision is acceptable because it has medical advantages, whereas female circumcision only has “social” advantages (eligibility for marriage, greater acceptance by the community, seen as more aesthetic, and so on).

I don’t think that’s the solution, either. First, the idea that “social” benefits are less important than “health” benefits would need some defending: I have already mentioned the pitfalls of capitulating to the domain of medicine in order to avoid having to think through complex moral issues. But let us just assume that all we care about is “health” for a moment and see where this exercise leads us.

Most of the decent-quality data showing health benefits for male circumcision (primarily, a modest reduction in the absolute risk of some sexually transmitted infections) come from surgeries performed on adults in Africa, not babies in the United States or Europe. The findings cannot be simply copy-pasted from one context and age range to another.

But even if you could just copy and paste, you would still have to factor in the risks and harms of circumcision, which are not trivial. In fact, most national medical associations to have issued formal policies on the question have found that the benefits of childhood male circumcision are not sufficient to outweigh the disadvantages of the surgery in developed countries.

(There is one glaring exception to this, which we’ll come back to.)

This suggests either that the scales are closely balanced, as the Canadian Pediatric Society claims, or actually tipped in the direction of net harm, as the Royal Dutch Medical Association has concluded. Further south, the Royal Australasian College of Physicians states: “the level of

protection offered by circumcision and the complication rates of circumcision do not warrant routine infant circumcision in Australia and New Zealand."

In any case, the existence of "some" health benefits (as opposed to net health benefits—and that would still not resolve the moral issues) would make for a very weak defense of the practice even on purely medical grounds.

Just think. Removing any healthy tissue from a child's body will confer "some" health benefits: tissue that has been excised can no longer host a cancer, become infected, or pose any other problem to its erstwhile owner. But as the bioethicist Eike-Henner Kluge has noted, if this logic were accepted more generally, "all sorts of medical conditions would be implicated" and we would find ourselves "operating non-stop on just about every part of the human body."

* * *

Alarmingly, one place we might start operating is the pediatric vulva. Compared to the penis, the external female genitalia provide if anything "an even more hospitable environment to bacteria, yeasts, viruses, and so forth, such that removing moist folds of tissue (with a sterile surgical instrument) might very well reduce the risk of associated problems."

In countries where female circumcision is relatively common, this is exactly what is claimed for the procedure. Cited health benefits include "a lower risk of vaginal cancer … fewer infections from microbes gathering under the hood of the clitoris, and protection against herpes and genital ulcers."

Moreover, at least two studies by Western scientists have shown a negative correlation between female circumcision and HIV. The authors of one of the studies, both seasoned statisticians who expected to find the opposite relationship, described their findings as a "significant and perplexing inverse association between reported female circumcision and HIV seropositivity."

None of these findings is conclusive. I am not saying that female "circumcision" can ward off HIV or any other disease. But let us just imagine that some of the above-cited health benefits are eventually confirmed. Would anti-FGM campaigners suddenly be prepared to say that female genital cutting was ethically acceptable?

I would be surprised if that turned out to be the case. In other words, even if health benefits do one day become reliably associated with some medicalized form of female genital cutting, I expect that opponents of the practice—including the WHO—would say, “So what?”

First, they would argue that healthy tissue is valuable in-and-of-itself, so should be counted in the “harm” column simply by virtue of being damaged or removed. Second, they would point to non-surgical means of preventing or treating infections, and suggest that these should be favored over more invasive methods. And third, they would bring up the language of rights: a girl has a right to grow up with her genitals intact, they would say, and decide for herself at an age of understanding whether she would like to have parts of them cut into or cut off.

The same arguments apply to male circumcision. But as Kirsten Bell has pointed out, the WHO steadfastly refuses to connect the dots. In her words, they seek to “medicalize male circumcision on the one hand” by promoting it, over the objections and reservations of many outside experts, as a form of prophylaxis against HIV. But they “oppose the medicalization of female circumcision on the other, while simultaneously basing their opposition to female operations on grounds that could legitimately be used to condemn the male operations.”

The problem with appeals to “health benefits,” then, is that they are disingenuous and inconsistently applied. As Robert Darby has argued, “official bodies working against FGC have condemned medicalization of the procedure and funded massive research programs into the harm of the surgery.” The irony, as he sees it, is that the WHO “also frames male circumcision as a public health issue—but from the opposite starting point.” Thus, we see that

> *“instead of a research program to study the possible harms of circumcision, it funds research into the benefits and advantages of the operation. In neither case, however, is the research open-ended: in relation to women the search is for damage, in relation to men it is for benefit; and since the initial assumptions influence the outcomes, these results are duly found.”*

Perhaps even more striking, the WHO's asymmetrical focus on health benefits could backfire. Specifically, it could open the door for supporters of female genital cutting to mount a defense of the procedure modeled on the male parallel.

To put it simply, if the sheer existence of health benefits is so compelling to organizations like WHO, these supporters might think, then all we have to do is generate the right kind of evidence, and we can fend off critics of our cherished custom.

* * *

There are already signs of this happening. At least one female Muslim gynecologist—from Khartoum University in the Sudan—has been reported as saying: "if the benefits [of female circumcision] are not apparent now, they will become known in the future, as has happened with regard to male circumcision."

(Perhaps she will be inspired by the websites of American plastic surgeons, who already claim all manner of physical and mental health benefits for elective labiaplasty – and other purported "cosmetic" operations).

Similarly, the anthropologist Fuambai Ahmadu has written about the women of Sierra Leone: "Why, one woman asked, would any reasonable mother want to burden her daughter with excess clitoral and labial tissue that is unhygienic, unsightly and interferes with sexual penetration … especially if the same mother would choose circumcision to ensure healthy and aesthetically appealing genitalia for her son?"

And what about the Dawoodi Bohra? As reported by Tasneem Raja, herself a member of the community and a former editor at NPR, some Bohra women believe that female circumcision, which they call khatna, "has something to do with 'removing bad germs' and liken it to male circumcision, which is widely … believed to have hygienic benefits."

It is currently illegal in Western countries to conduct a properly controlled scientific study to determine whether a "mild," sterilized form of female genital cutting carried out in infancy or early childhood confers some degree of protection against disease.

But if anti-FGM organizations such as the WHO continue to play the “no health benefits” card as a way of deflecting comparisons to male circumcision, it will not be long before medically-trained supporters of the practice in other countries begin to do the necessary research.

* * *

The history of male circumcision shows how this could happen. Alongside female genital cutting, male genital cutting originated in African prehistory as a ritual practice, and was later adopted by various Semitic tribes. For most of its existence, the only claimed advantages of the procedure were social or metaphysical in nature—identifying the boy as a member of a particular group, for example, or sealing a divine covenant, as in Judaism.

In the physical realm, by contrast, circumcision was largely believed to have negative effects, including on sexual feeling and satisfaction. By “dulling” the sexual organ of male children, parents believed that their sons would pay more attention to important “spiritual” matters and be less tempted by the pleasures of the flesh.

It was only in recent times that religious supporters of male circumcision began to argue that it was “physically” beneficial—recasting the procedure as a secularly defensible measure of individual or even public health, as opposed to solely a cultural or religious practice.

In the United States, for example, circumcision was adopted in part as an anti-masturbation tactic in the late 1800s (masturbation, at the time, was thought to cause not only moral but medical ills; see here for a video introduction). The resulting shift from “religious” to “medical” proved strategically important in Christian-majority societies, where genital cutting of children had otherwise been seen as barbaric.

The medical historian David Gollaher has argued that Jewish physicians, whose “attitudes toward circumcision were partly shaped by their own cultural experience,” found the late 19th century evidence of health benefits “especially compelling.” Most of it was later debunked.

Nevertheless, the search for “health benefits” continues to this day. A large proportion of the current medical literature purporting to show health benefits for male circumcision has been generated by doctors who were themselves circumcised at birth—often for religious reasons—and who have cultural, financial, or other interests in seeing the practice preserved.

* * *

Science and medicine are not immune from such agendas or biases. In 2012, the American Academy of Pediatrics (AAP) controversially concluded that the health benefits of newborn male circumcision outweighed the risks (this is the “glaring exception” I said I’d come back to). Their conclusion was puzzling, since they did not have a method for assigning weights to individual benefits or risks, much less an accepted mechanism by which the two could be compared.

They were also missing the denominator to their equation. On page 772 of their report they state that, due to limitations with the existing data, “the true incidence of complications after newborn circumcision is unknown.”

So how could we know they are outweighed by the benefits?

In an unprecedented move, the AAP was rebuked by senior physicians, ethicists, and representatives from national medical societies based in the UK, Canada, and mainland Europe, who argued that the findings were likely culturally biased. The AAP Circumcision Task Force later acknowledged that the benefits were only “felt” to outweigh the risks. It came down to a subjective judgment.

Reflecting on the debacle in a recent editorial, Task Force member Andrew Freedman tried to explain how he and his colleagues had reached a different conclusion to that of their peers in other countries despite looking at the same medical evidence. In doing so, he made a revealing comment:

> *Most circumcisions are done due to religious and cultural tradition. In the West, although parents may use the conflicting medical literature to buttress their own beliefs and desires, for the most part parents choose what they want for a wide variety of nonmedical reasons. There can be no doubt that religion, culture, aesthetic preference, familial identity, and personal experience all factor into their decision.*

In a separate interview, Freedman stated that he had circumcised his own son on his parents' kitchen table. "But I did it for religious, not medical reasons," he wrote. "I did it because I had 3,000 years of ancestors looking over my shoulder."

Arguing that it is "not illegitimate" for parents to consider such social and spiritual "realms [in] making this nontherapeutic, only partially medical decision," Freedman went on to say that "protecting" the parental option to circumcise "was not an idle concern" in the minds of the AAP Task Force members "at a time when there are serious efforts in both the United States and Europe to ban the procedure outright."

* * *

The women in societies that practice what they call female circumcision are just as devoted to their cultural traditions as are the men who practice genital cutting of boys. They don't want their customs banned either. If "medical benefits" are sufficient to ward off condemnation, a strong incentive will exist to seek them out.

I suggest, therefore, that by repeating the mantra—in nearly every article focused on female genital cutting—that "FGM has no health benefits," those who oppose such cutting are sending the wrong signal. The mantra implies that if FGM did have health benefits, it wouldn't be so bad after all.

But that isn't what opponents really think. Regardless of health consequences, they see nontherapeutic genital cutting of female minors as contrary to their best interests, propped up by questionable social norms that should themselves be challenged and changed.

I would go one step further. All children—female, male, and intersex—have a compelling interest in intact genitalia. All else being equal, they should get to decide whether they want their “private parts” nicked, pricked, labiaplastied, “normalized,” circumcised, or sewn, at an age when they can appreciate what is really at stake.

This doesn’t mean a “ban” on such procedures before an age of consent is necessarily the best way to go. As I have explained elsewhere, legal prohibition can be a clumsy way of bringing about social change, often causing more harm than good. I worry, for example, that taking young girls out of their homes, invasively examining their genitals in search of “evidence,” and throwing their parents—who no doubt love them—in jail, could be more traumatic than the initial act of cutting.

As for the Dawoodi Bohra case, we will just have to see how the judge interprets—and applies—the existing laws.

My own preference is for debate and dialogue, not bans and vilification. But whatever approach one takes, it is time to move beyond the tired (and false) dichotomies of male versus female, religion versus culture, and health benefits versus no health benefits. The focus for critics of genital cutting going forward, I contend, should be on children versus adults—that is, on bodily autonomy and informed consent.

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